

# Mistahey Musqua Treatment Centre



Box 404 Loon Lake,  
Saskatchewan  
S0M 1L0

Phone: (306) 837-2184 Fax: (306) 837-4414

**MISTAHEY MUSQUA TREATMENT CENTRE**  
**ADMISSION POLICY**

1. THE APPLICANT MUST BE EIGHTEEN YEARS OLD OR OLDER TO ATTEND SERVICES.
2. CLIENTS MUST BE SOBER FOR A MINIMUM OF 2 WEEKS PRIOR TO TREATMENT AT THE MMTc.
3. IN THE EVENT THAT MMTc STAFF SUSPECTS DRUG/ ALCOHOL USE A BREATHALYZER TEST WILL BE DONE; IF THE MMTc FINDS THAT A CLIENT HAS USED THE CLIENT WILL BE TERMINATED FROM TREATMENT.
4. CLIENTS WILL BE ON A 14 DAY BLACKOUT; THERE WILL BE NO VISITS OR PHONE CALLS DURING THE FIRST 14 DAYS IN TREATMENT.
5. ALL REFERRAL AGENTS ARE RESPONSIBLE FOR TRANSPORTING THEIR CLIENT TO MMTc. TRANSPORTATION ARRANGEMENTS TO AND RETURNING BACK TO THEIR COMMUNITY, WILL BE THE RESPONSIBILITY OF THE COMMUNITY, OR REFERRAL AGENT. IF THE CLIENTS USE THEIR OWN MEANS OF TRANSPORTATION; MMTc WILL REQUIRE THE KEYS TO BE TURNED IN UPON ARRIVAL.
6. MMTc IS RESPONSIBLE TO PROVIDE INPATIENT TREATMENT SERVICES TO MEMBERS OF THE NINE FIRST NATIONS BANDS WHICH CONFORM MLTC; IF THE FULL CAPACITY IS NOT MET, MMTc WILL ACCEPT OTHER FIRST NATIONS APPLICANTS, NON-STATUS, METIS, AND NON-FIRST NATIONS FROM ANYWHERE IN CANADA.
7. MMTc WILL NOT ACCEPT NEW CLIENTS DURING THE CYCLE PROGRAM. NO EXCEPTIONS.
8. CLIENT MUST ARRIVE ON THE INTAKE DATE SCHEDULED; NO LATER.
9. THE ADMISSION POLICY, HOUSE GUIDELINES, APPLICATION FORM, MEDICAL EXAMINATION FORM, AND CONDITIONS OF AGREEMENT FORM NEED TO BE SIGNED AND COMPLETED BY THE APPLICANT AND THE REFERRAL AGENT AND THEN SUBMITTED FOR SCREENING TO MMTc.
10. THE APPLICATIONS WILL BE REVIEWED AND APPROVED BY THE MMTc TEAM.
11. A LETTER OF CONFIRMATION OF ACCEPTANCE IS NECESSARY IN ORDER TO BE ADMITTED IN THE PROGRAM.
12. THE CLIENTS ARE RESPONSIBLE TO ARRANGE THEIR OWN LEGAL, MEDICAL AND OTHER PERSONAL MATTERS TO BE TAKEN CARE OF **BEFORE** OR **AFTER** THE TREATMENT PROGRAM. NO EXCEPTIONS.
13. PRESCRIBED MEDICATION AND OVER THE COUNTER DRUGS WILL BE RETAINED BY MMTc.
14. MMTc IS REQUIRED TO INSPECT THE CLIENTS' BELONGINGS UPON ADMITTANCE.
15. THE REFERRAL AGENTS ARE RESPONSIBLE FOR THE CLIENTS DURING TREATMENT.
16. IN THE EVENT THAT A CLIENT BECOMES AGGRESSIVE; THE MMTc HAS THE RIGHT TO USE NON-ABUSIVE PHYSICAL RESTRAINT. IF PHYSICAL RESTRAINT MUST BE USED THE CLIENT WILL BE TERMINATED.
17. MMTc HAS THE RIGHT TO TERMINATE ANY CLIENT THAT DOES NOT WANT TO FOLLOW THE TREATMENT PLAN OR RULES OF MMTc.

**I UNDERSTAND AND AGREE WITH THE ADMISSION POLICY.**

**Client Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**MISTAHEY MUSQUA TREATMENT CENTRE**  
**HOUSE GUIDELINES**

THE MISTAHEY MUSQUA TREATMENT CENTRE OFFERS ADDICTIONS TREATMENT SERVICES TO PEOPLE WITH ALCOHOL, DRUGS AND GAMBLING PROBLEMS. DURING YOUR STAY, WE WILL WORK WITH YOU TO CHANGE THESE PROBLEMS AND WE ASK YOU TO FOLLOW MMTc ADDICTIONS TREATMENT PLAN.

1. AT NO TIME WILL CLIENT THREATEN OR TRY TO INTIMIDATE MMTc STAFF OR OTHER CLIENTS DURING THE 32 DAY PROGRAM, FAILURE TO COMPLY WILL RESULT IN IMMEDIATE DISMISSAL FROM THE PROGRAM.
2. IN THE EVENT THAT MMTc CLIENT BECOMES PHYSICALLY AGGRESSIVE OR THREATENING TOWARDS STAFF OR CLIENT; THE MMTc WILL CONTACT RCMP TO REMOVE THE CLIENT FROM THE PREMISES.
3. WE HAVE A PROGRAM WITH PLANNED ACTIVITIES; PLEASE FOLLOW THE PROGRAM AND PARTICIPATE DURING ALL THE ACTIVITIES.
4. DURING BLACKOUT, THERE WILL BE NO PHONE CALLS OR VISITORS FOR 14 DAYS.
5. SMOKING IS ALLOWED ONLY IN DESIGNATED AREAS.
6. DRINKS AND FOOD ARE ALLOWED IN THE DINING ROOM ONLY.
7. CLIENTS ARE NOT ALLOWED TO PURCHASE ENERGY DRINKS DURING THEIR THIER STAY AT MMTc.
8. CELL PHONES AND ELECTRONICS ARE NOT ALLOWED. THE PAYPHONE IS EXCLUSIVE FOR CLIENTS AND HAS SPECIFIC TIMES.
9. NO TV DURING SESSIONS; FAILURE TO COMPLY WITH THE RULES WILL RESULT IN A VERBAL WARNING.
10. NO PHONE CALLS BETWEEN THE HOURS OF 9 AM – 12 PM & 1 PM – 4 PM.
11. PAYPHONES ARE NOT TO BE USED AFTER 11 PM.
12. CLIENTS WILL NOT ASK STAFF TO USE OFFICE PHONES FOR ANY REASON; **NO EXCEPTIONS.**
13. SEXUAL RELATIONSHIPS ARE NOT PERMITTED AT ANY TIME BETWEEN CLIENTS/ STAFF DURING YOUR STAY.
14. CLIENTS ARE EXPECTED TO BE AWAKE BY 7 AM EACH MORNING; EXCEPT ON WEEKENDS CLIENTS SHOULD BE AWAKE BY 8 AM.
15. LIGHTS OUT EVERY EVENING BY 11 PM FROM SUNDAY TO FRIDAY; SATURDAY WILL BE 12 AM.
16. TV, RADIO OR ANY OTHER MUSIC SHOULD BE OFF BY 11 PM EACH NIGHT.
17. CLIENT OUTINGS ARE A PRIVILEGE AND CAN BE TAKEN AWAY IN THE EVENT THAT A MMTc COUNSELLOR FINDS IT NECESSARY TO DO SO.
18. NO LOUD MUSIC DURING CLIENT OUTINGS, PLEASE RESPECT OTHER CLIENTS AND STAFF.
19. CLIENTS ARE RESPONSIBLE FOR MAKING THEIR BEDS AND CLEANING THEIR ROOMS EACH MORNING AND REPLACING THEIR SHEETS EVERY SATURDAY.
20. CLIENTS WILL BE ASSIGNED SPECIFIC HOUSEKEEPING DUTIES WHICH WILL BE ROTATED ON A WEEKLY BASIS; FAILURE TO COMPLY COULD LEAD TO DISCIPLINARY ACTION.
21. CLIENTS ARE EXPECTED TO ATTEND ALL LECTURES, INCLUDING A.A MEETINGS, OUTSIDE MEETINGS, RECREATION AND OTHER GROUP ACTIVITIES.
22. DORMITORIES ARE DESIGNATED FOR MALE AND FEMALES; MEN ARE NOT ALOWED IN WOMAN’S ROOMS AND VICE-VERSA.
23. DURING TREATMENT; CLIENTS ARE NOT ALLOWED TO VISIT HOMES OR RELATIVES.
24. RESPECT ONE ANOTHER’S CUSTOM AND BELIEFS.
25. DRESS PROPERLY AND ACCORDINGLY WHILE IN TREATMENT.
26. STAFFS ARE NOT RESPONSIBLE FOR ANY ITEMS LEFT BEHIND.
27. VIOLENCE OR THREATS AGAINST STAFF WILL NOT BE TOLERATED; FAILURE TO COMPLY COULD LEAD TO AUTOMATIC TERMINATION OF TREATMENT.

28. ALCOHOL AND DRUG USE IS **PROHIBITED**.
29. IF THE CLIENT IS SUSPECTED OF USING ANY SUBSTANCES A BREATHALYZER TEST WILL BE DONE.
30. IF THE COUNSELLOR FINDS THAT THE CLIENTS HAS BEEN USING ANY SUBSTANCES WHILE IN TREATMENT THE CLIENT WILL BE TERMINATED.
31. ROOMS WILL BE INSPECTED BY STAFF ON A REGULAR BASIS.
32. NO SWEARING ALLOWED AT ANY TIME DURING YOUR STAY; YOU WILL BE GIVEN 2 WARNINGS; A THIRD WARNING IS GROUNDS FOR DISMISSAL FROM THE PROGRAM.
33. THERE WILL BE TWO WARNINGS, IF ANY RULES ARE BROKEN AFTER THE THIRD WARNING YOU WILL BE **TERMINATED** FROM THE PROGRAM.
34. MMTC WILL DEAL THE MATTER ACCORDINGLY; IF GUIDELINES ARE NOT MET BY CLIENTS.

I UNDERSTAND AND AGREE TO FOLLOW THESE HOUSE GUIDELINES.

Client Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**MISTAHEY MUSQUA TREATMENT CENTRE**  
**APPLICATION FORM**

THIS APPLICATION IS THE FIRST STEP REQUIRED FOR ANY ADULT PERSON INTERESTED IN PARTICIPATING IN THE ADDICTIONS TREATMENT PROGRAM AT MISTAHEY MUSQUA TREATMENT CENTRE.

INSTRUCTIONS FOR THE CLIENT: You must fill this form with the help of your referral agent.

**General Information:**

Application date: \_\_\_\_\_ Email address: \_\_\_\_\_

First Name(s): \_\_\_\_\_ Last Name(s): \_\_\_\_\_ Nickname(s): \_\_\_\_\_

Gender: Male \_\_\_\_\_ Female \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Status Indian: Yes \_\_\_\_\_ No \_\_\_\_\_

First Nation Band: \_\_\_\_\_ Treaty Number: \_\_\_\_\_

Health Card Number: \_\_\_\_\_ S.I.N #: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_

Province: \_\_\_\_\_ Postal code: \_\_\_\_\_ Phone #: \_\_\_\_\_

Education Level: Grade 1-6 \_\_\_\_\_ Grade 6-9 \_\_\_\_\_ Grade 9-12 \_\_\_\_\_ Post – Secondary \_\_\_\_\_

Employment: Full-time \_\_\_\_\_ Part-time \_\_\_\_\_ Unemployed \_\_\_\_\_ Seasonal \_\_\_\_\_ Student \_\_\_\_\_

**Emergency Contact Information:**

Name: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

Address: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Fax Number: \_\_\_\_\_ Email: \_\_\_\_\_

**Family/ Relationships:**

1. What is your marital status?

\_\_\_\_\_

2. Does the client have dependent children?

---

3. If yes, does the client have access to adequate child care while in Treatment?

---

4. Are the children currently in care?

---

5. Does the client have any other dependants under the age of 18?

---

**Treatment History:**

6. Have you previously attended any treatment services? Explain.

---

7. Did you complete your previous treatment services? Please explain why, or why not.

---

8. Which other agencies/ services are you currently involved with?

NNADAP: \_\_\_\_\_ WELLNESS: \_\_\_\_\_ PROBATION: \_\_\_\_\_ MEDICAL: \_\_\_\_\_ CHILD/ FAMILY: \_\_\_\_\_

Please Explain:

---

9. Have you ever been refused treatment, or terminated from treatment? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

**Legal History:**

10. Has the client been ordered to attend treatment? If yes, please provide a copy of court order.

---

11. Have you ever been convicted of a criminal offense? Yes \_\_\_\_\_ No \_\_\_\_\_

---

12. What was the outcome of your conviction?

Incarcerated: \_\_\_\_\_ Conditional Sentence: \_\_\_\_\_ Monitor: \_\_\_\_\_ Probation: \_\_\_\_\_ Bail: \_\_\_\_\_

Temporary Absence: \_\_\_\_\_ Other, please explain: \_\_\_\_\_

13. Were you under the influence of any drugs/ alcohol at the time of the offence? If yes, explain.

---

14. Do you have any current outstanding charges? If yes, please explain.

---

15. Is the client under any of the following legal conditions?

N/A: \_\_\_\_\_ Probation: \_\_\_\_\_ Bail: \_\_\_\_\_ Early release: \_\_\_\_\_ Conditional sentence: \_\_\_\_\_ Parole: \_\_\_\_\_

**Note:** Please fax the probation order, or the conditions with this assessment.

\*\*\* CLIENTS MUST BE FREE FROM ANY LEGAL APPOINTMENTS (EX: PROBATION, COURT APPEARANCES, ETC.) DURING THEIR STAY AT THE MMTC. \*\*\*

**Mental History:**

16. Have you ever had any suicide attempts or thoughts? If yes, please explain.

---

17. Have you ever had a mental health assessment and been diagnosed with a mental illness? If yes, please explain.

---

**Social Profile:**

18. Which of the following areas have been negatively affected by your use?

School attendance: \_\_\_\_\_ Family Relationships: \_\_\_\_\_ Physical Health: \_\_\_\_\_

Employment: \_\_\_\_\_ Psychological Health: \_\_\_\_\_ Legal Situation: \_\_\_\_\_ Other: \_\_\_\_\_

---

19. Have you or any family member ever attended residential school? Yes \_\_\_\_\_ No \_\_\_\_\_

Please provide details:

---

---

**Withdrawal Symptoms:**

20. Has the client experienced any withdrawal symptoms such as blackouts, hallucinations, nausea/ vomiting, seizures, or delirium tremens within the last 6 months? If yes, please explain.

---

21. What are your behavioural patterns when you are under the influence of drugs/ alcohol?

Aggressive: \_\_\_ Argumentative: \_\_\_ Less shy: \_\_\_ Quiet: \_\_\_ Outgoing: \_\_\_ Withdrawn: \_\_\_

Other, please explain:

---

**Continuing Care:**

22. What kind of support does the client have back home? Please Describe.

---

---

23. Would you be interested in returning for the annual two week refresher program at MMTC?

---



**Substance use profile:**

24. What type of drugs/ alcohol/ substances have you used?

(Please check off the one's you have used & the time that you last used.)

When did you last use the substance?	Last 24 hours	2 – 7 days	8 – 30 days	Over 1 month	Over 1 year
<input type="radio"/> Alcohol					
<input type="radio"/> Marijuana					
<input type="radio"/> Crack Cocaine					
<input type="radio"/> Cocaine					
<input type="radio"/> Ecstasy					
<input type="radio"/> Crystal Meth					
<input type="radio"/> Heroin					
<input type="radio"/> Talwin & Ritalin					
<input type="radio"/> Antidepressants					
<input type="radio"/> Prescription Drugs					
<input type="radio"/> Hallucinogens					
<input type="radio"/> Morphine					
<input type="radio"/> Inhalants					
<input type="radio"/> Tobacco					
<input type="radio"/> Snuff					
<input type="radio"/> Caffeine					
<input type="radio"/> Other					

25. What kind of drugs/ alcohol/ substances do you currently use?

---

26. How frequently do you use them?

---

27. What is your pattern of use? Daily: \_\_\_\_\_ Weekly: \_\_\_\_\_ Binges: \_\_\_\_\_ Other: \_\_\_\_\_

28. What is the longest time you've been able to stay sober?

---

29. What was the reason that you were able to stay sober?

---

30. Do you have any of the following "process" addictions?

Gambling \_\_\_\_ Relationship(s) \_\_\_\_ Shopping: \_\_\_\_ Workaholic: \_\_\_\_ Sex: \_\_\_\_ Other: \_\_\_\_

If yes, please explain which:

---

31. Do you feel that you have an alcohol, drug problem, and or gambling problem? Explain.

---

32. Why are you seeking addiction services with the Mistahey Musqua Treatment Centre?

To get your children back: \_\_\_\_ Required by employer: \_\_\_\_ Court Order: \_\_\_\_ Health: \_\_\_\_

Personal choice: \_\_\_\_\_ Other, please explain: \_\_\_\_\_

**Other information:**

33. Does the client have cultural and/ or spiritual beliefs we need to be aware of?

---

34. Does the client have any literacy or learning needs we should be aware of?

---

**I understand the questions that have been asked, and I swear that my answers are true.**

Client Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MISTAHEY MUSQUA TREATMENT CENTRE**  
**REFERRAL AGENT FORM**

**Referral Information:**

Referral Name: \_\_\_\_\_ Position: \_\_\_\_\_

Agency: \_\_\_\_\_ Mailing Address: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_ Email: \_\_\_\_\_

**Client Information:**

1. From your professional experience working with the client, what is motivating this client to receive inpatient services at this time?

---

---

---

2. With your professional opinion, what are the most important areas this client needs to address during treatment?

---

---

---

3. Are you aware of any factors in this clients' life that may pose as a threat to other clients in an inpatient setting? (Medical conditions, legal charges, etc.)

---

---

---

**Services Provided:**

4. Until today, how have you been involved in the clients' personal development?

---

---

5. Has this client been referred to and denied services at any other center?

---

---

6. Are there any other community services currently involved in trying to assist this client?

---

7. Is the client willing to participate in First Nations Traditional activities at the MMTC?

---

8. Have you completed a SASSI or other form of assessment? If yes, please include a copy.

---

9. What services will you provide the client after the program completion?

---

---

**\*\*Please be advised that incomplete application forms may not be considered if they are missing important information, please complete the application.\*\***

**Referral Agent Oath**

I certify that the information contained in this section is true to the best of my knowledge.

Referral Agents' Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**MISTAHEY MUSQUA TREATMENT CENTRE**  
**MEDICAL EXAMINATION FORM**

THIS MEDICAL EXAMINATION FORM HAS TO BE COMPLETED BY LICENSED PHYSICIAN OR NURSE PRACTITIONER AND ATTACHED TO THE APPLICATION FORM.

**CLIENT INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Nickname(s): \_\_\_\_\_ Address: \_\_\_\_\_

DOB: \_\_\_\_\_ Health Card Number: \_\_\_\_\_ Gender: M \_\_\_ F \_\_\_

**PHYSICIAN INFORMATION**

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Please check yes or no to indicate if client is currently being treated for or if He/She has a history of any of the following:

CONDITIONS	WHEN AND GIVE DETAILS IF APPLICABLE		
	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Tuberculosis</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Heart Disease</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Mental Illness</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Epilepsy</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Seizure (Other than epilepsy)</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>High Blood Pressure</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Cancer</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Allergy</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Stroke</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Diabetes</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Back Pain</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Venereal Disease</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Emphysema or other lung disease</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>HIV/AIDS</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Hepatitis A, B, C</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Scabies</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Lice</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
<b>Pregnancy</b>	<input type="checkbox"/> YES	<input type="checkbox"/> NO	LMP / /20 Live births:

Please indicate current medications for medical reasons; the MMTC will not accept unnecessary prescription drugs or over the counter drugs and clients requiring acute care or detoxification services.

CURRENT MEDICATIONS	DOSAGE	REASON/COMMENTS


PLEASE LIST ANY FURTHER INFORMATION THAT YOU THINK MAY BE OF BENEFIT TO THIS CENTRE

**\*\*IF A FULL PHYSICAL EXAMINATION WAS DONE PLEASE PROVIDE A COPY\*\***

**Nurse or Doctor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I UNDERSTAND THAT I GIVE AUTHORIZATION TO RELEASE ANY MEDICAL INFORMATION TO MMTC FROM THE ABOVE PHYSICIAN

**Patient Signature:** \_\_\_\_\_



**MISTAHEY MUSQUA TREATMENT CENTRE**  
**CONDITIONS OF AGREEMENT**

IN ORDER TO COMPLETE THE ADDICTIONS TREATMENT PROGRAM AND PROVIDE APPROPRIATE CARE TO ALL; THE FOLLOWING CONDITIONS MUST BE AGREED UPON BEFORE ANY APPLICATION CAN BE ACCEPTED.

1. I FULLY UNDERSTAND THAT THE CONSUMPTION OR POSSESSION OF ALCOHOL OR NON-PRESCRIBED DRUGS ARE NOT PERMITTED AT ANY TIME. THE VIOLATION OF THIS CONDITION WILL RESULT IN IMMEDIATE DISMISSAL FROM MMTC.
  
2. I AGREE TO FOLLOW THE INSTRUCTIONS THAT MAY BE GIVEN VERBALLY AND IN WRITING BY MMTC STAFF.
  
3. I AGREE THAT I HAVE READ THE APPLICATION, ADMISSION POLICY, HOUSE GUIDELINES, AND CONDITIONS OF AGREEMENT FORM AND THAT I UNDERSTAND THE RULES & GUIDELINES OF THE MMTC.
  
4. I AGREE THAT MMTC AND ITS STAFF ARE UNDER NO OBLIGATION FOR THE SAFEKEEPING OF ANY OF MY PERSONAL PROPERTY AND ARE NOT LIABLE FOR ANY LOSS AND DAMAGE OF SUCH.
  
5. I AGREE TO PARTICIPATE IN ALL THE MMTC PROGRAM ACTIVITIES.
  
6. I UNDERSTAND THAT I CANNOT HOLD MMTC AND ITS STAFF RESPONSIBLE FOR ANY PHYSICAL AILMENT OR INJURY THAT MAY DEVELOP DURING MY STAY IN THEIR FACILITY. (I.e. fishing, snaring, and outdoor activities).

**I UNDERSTAND AND AGREE TO THEIR CONDITIONS.**

\_\_\_\_\_  
**CLIENT SIGNATURE**

\_\_\_\_\_  
**DATE**

# Mistahey Musqua Treatment Centre

## Client checklist of what to bring: (Please review with the client)

- ✓ Alcohol free personal hygiene products (shampoo, soap, toothbrush, etc.)
- ✓ Feminine products ( tampons, pads)
- ✓ 32 days of prescribed medication ( to be turned in at intake day)
- ✓ Spending money & calling cards (Vox, Presidents choice, Bravo work on payphones)
- ✓ Cigarettes for 32 days
- ✓ Identification
- ✓ Appropriate clothing and footwear for the time of season
- ✓ Optional: bedding & towels
- ✓ For the women a skirt for sweat ceremonies

## Client's what NOT to bring:

- ✓ Provocative/inappropriate clothing or reading materials
- ✓ Personal gaming & music devices
- ✓ Perfumes/cologne
- ✓ Cell phones (if bringing one it will be locked up for 32 days)
- ✓ **Illegal drugs**
- ✓ **Weapons**

**Please note:** On intake day, there will be bag searches. Any illegal drugs, weapons & hidden cell phones will be grounds for immediate dismissal or not allowed entry into the treatment program. Drug testing will be done the day of arrival.

**All court proceedings and medical appointments must be dealt with prior to admission, as client cannot leave during the 32 day stay.**